EXHIBIT 2

Redacted SC Workers' Compensation Commission Claim

South Carolina Workers' Compensation Commission
1333 Main Street, Suite 500
P.O. BOX 1715
Columbia, SC 29202-1715
(803) 737-5723

WCC File #: 2207465
Carrier File #: E2G65611 J2
Carrier Code #: 127-1
Employer FEIN #: 20-1998367

Claimant's Name: [redacted]
Address: [redacted]
City: Summerville State: SC Zip: 29485-8172
Home Phone: [redacted] Work Phone: ( ) -

Employer's Name: Weston & Sampson Inc.
Address: 55 Walkers Brook Dr, Ste 100
City: Reading State: MA Zip: 01867-3272
Insurance Carrier: National Fire Insurance Company Of Hartford

Preparer's Name: Kristina Dickson Law Firm: Preparer's Phone #: (877)371-5121

Compensation Paid:	Number of Weeks	From (m/d/yyyy)	To (m/d/yyyy)	Amount
1. Number of Weeks T.T.				$
2. Number of Weeks T.P.				$
3. Number of Weeks P.P.				$
4. Disfigurement				$
5. Agreement and Final Release				$
Total Compensation Paid				$ 0.00
6. Total Medical Benefits* Paid				$
7. Funeral Benefits				$

☒ Case Denied

Date of Injury: 03/31/2022 (m/d/yyyy)

By signing this receipt, I acknowledge that I have received the compensation shown above.

By: _____ Claimant

By: _____ Employer's Representative

_____ Date (m/d/yyyy)

_____
Print or type the name of the person, other than the claimant, receiving benefits and sign below.

By: _____

Report of Additional Fees and Recoupment

A. Carrier Reimbursement by Third Party		$
B. Attorney's Fee Paid by Employer		$
C. Attorney's Fee Paid by Claimant (Non-contingent fees only)		$

File this form with the Claims Department according to R.67-414 and R.67-1204. A person, other than the claimant, receiving benefits should sign on the line provided. * Do not include as medical costs fees paid for expert testimony, fees for determining carrier's liability, costs of autopsy, birth and death certificates and impartial examination. Form 19 must be filed within 16 days of final payment of compensation. Form 19 must be filed when a claim is denied.